

**U.S. Department of Labor**

Office of Administrative Law Judges  
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**Issue Date: 30 April 2003**

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In the Matter of

MRS. CARRIE B. BANKS, widow of  
MR. JOHN W. BANKS  
Claimant

Case No.: 2001 BLA 1175

v.

BETTY B. COAL COMPANY  
Employer  
and  
LIBERTY MUTUAL INSURANCE  
Carrier

and  
DIRECTOR, OFFICE OF WORKERS'  
COMPENSATION PROGRAMS  
Party in Interest

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Appearances: Mr. Ron Carson, Personal Representative  
For the Claimant

Mr. H. Ashby Dickerson, Attorney  
For the Employer

Before: Richard T. Stansell-Gamm  
Administrative Law Judge

**DECISION AND ORDER - AWARD OF BENEFITS**

This matter involves a survivor claim filed by Mrs. Carrie B. Banks, widow of Mr. John W. Banks, for benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Pursuant to a Notice of Hearing, dated March 26, 2002, I conducted hearing on June 25, 2002 in Abingdon, Virginia with Mrs. Banks, Mr. Carson and Mr. Dickerson present. My decision

in this case is based on all documents in the record (DX 1 to DX 51, CX 1, and EX 1 to EX 17).<sup>1</sup>

## **ISSUES**

1. Whether Betty B. Coal Company established good cause in order to controvert Mrs. Banks' survivor claim.
2. Whether Mr. Banks' death was due to coal workers' pneumoconiosis.

## **Coal Miner's Background**

Born November 12, 1933, Mr. John Wesley Banks married Mrs. Carrie Banks on October 7, 1961 (DX 2 and DX 7). Beginning at age 17, Mr. Banks worked in the mines hand-loading coal (TR, page 15). Later in his coal mining career, he was employed by Betty B. Coal Company, where he worked as a Joy Helper and Joy Operator from 1973 through 1979 (DX 4). His last job involved running a Joy, a machine that scoops up the coal after its been cut, and required pulling levers and turning controls (TR, page 23). Mr. Banks retired from the mines in 1979 because of back pain due to arthritis of the spine (DX 48-7 and DX 49-1, TR, page 17). In addition, Mr. Banks smoked between 1/2 to 1 pack of cigarettes a day for up to 15 years (DX 48-7 and DX 49-9), but cut back after his heart attack in 1987 (TR, page 27). He experienced difficulty breathing at night and had trouble sleeping due to breathing problems (TR, page 19). Mr. Banks passed away from aspiration pneumonia on September 10, 1996 (DX 8).

## **Procedural Background**

### Mr. Banks' Living Miner Claims

#### *First Claim* (CX 48)

Mr. Banks filed his first claim for benefits under the Act on April 13, 1973. The Social Security Administration denied his claim on July 29, 1979. Upon review, the U.S. Department of Labor also denied the claim because Mr. Banks failed to establish that he had coal workers' pneumoconiosis or that he was totally disabled due to black lung disease.

#### *Second Claim*

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<sup>1</sup>The following notations appear in this decision to identify exhibits: DX - Director exhibit; CX - Claimant exhibit; EX - Employer exhibit; and ALJ - Administrative Law Judge exhibit.

(DX 49)

Mr. Banks filed his second (duplicate) claim on August 23, 1982. The Benefits Review Board ("Board") finally denied the claim on October 30, 1990. The Board affirmed the administrative law judge's finding that the claimant established the existence of pneumoconiosis, but failed to prove that he was totally disabled due to a respiratory impairment.

#### Mrs. Banks' Survivor Claim

After the death of her husband, Mrs. Carrie Banks filed her own application for survivor benefits on March 7, 1997 (DX 2). In a Notice of Initial Finding, dated May 21, 1997, the District Director determined that an award of survivor benefits to Mrs. Banks was appropriate (DX 15). In the alleged absence of a timely response for the Employer, the District Director awarded benefits to Mrs. Banks on July 2, 1997 (DX 20). Prior to the award and over the course of the following months, the District Director and the Employer's counsel engaged in a disagreement on whether the Employer had received Notice of the Initial Finding and whether its insurer, Liberty Mutual, had presented a timely controversion. On September 17, 1997, the District Director again awarded benefits to Mrs. Banks (DX 44). In response, on September 29, 1997, counsel for the Employer continued to contest its liability and the timely response issue (DX 47). On August 20, 2001, the District Director forwarded the claim to the Office of Administrative Law Judges ("OALJ") for a formal hearing (DX 50 and DX 51).<sup>2</sup>

### **FINDINGS OF FACT AND CONCLUSIONS OF LAW**

#### **Stipulations of Fact**

During the administrative hearing on June 25, 2002, the parties stipulated that: a) Mrs. Banks is an eligible survivor under the Act; b) Mr. Banks had coal workers' pneumoconiosis; c) Mr. Banks had at least 14 years of post-1969 coal mine employment; d) Mr. Banks' pneumoconiosis was caused at least in part by his coal mine employment; and e) Betty B. Coal Company is the Responsible Operator (TR, pages 8-10, and 21).

#### **ISSUE NO. 1 - GOOD CAUSE**

According to the Director, the operator in this case, Betty B. Coal Company, is bound by the determination in the May 21, 1997 Notice of Initial Findings that Mrs. Banks is entitled to survivor benefits because the coal company did not respond within thirty days as required by 20 C.F.R. § 725.413 (DX 23). Counsel for Betty B. Coal Company contests that determination on two grounds. First, OWCP failed to send the Notice of Initial Findings to the coal mine operator (DX 38). Second,

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<sup>2</sup>The record contains no information concerning the four year delay in forwarding this case to OALJ. Likewise, neither party at the hearing was able to provide an insight into the delay. Mrs. Banks has been receiving interim benefits since the District Director's approval of her claim in July 1997.

because the coal company's insurer, Liberty Mutual Insurance Company, did not receive the Notice of Initial Findings until June 19, 1997, the coal company's controversion on July 14, 1997, through its counsel, received by OWCP on July 17, 1997, is timely under 20 C.F.R. § 725.413 (DX 25).

Prior to considering the applicable regulatory provisions, setting out the chronology of events is helpful.

OWCP sends an April 10, 1997 Notice of Claim to both Betty B. Coal Company (Coeburn, VA) and its insurer, Liberty Mutual Insurance (Richmond, VA) (DX 13).

In response to the Notice of Claim, Liberty Mutual informs OWCP on May 6, 1997, that it is raising all defenses and reserves the right to litigate the claim (DX 14).

Attached to a letter to Mrs. Banks from OWCP with a stamped date of May 21, 1997, is an Notice of Initial Findings, holding the responsible operator, Betty B. Coal Company, liable for the payment of survivor benefits to Mrs. Banks (DX 15).

The OWCP certified mail log shows two certified mail numbers are assigned on May 22, 1997 to letters to Mrs. Banks and Liberty Mutual Insurance Company (DX 16). Notably, the log contains no entry for Betty B. Coal Company.

According to the Post Office records, the letter containing the Notice of Initial Findings, with the certified number associated in the OWCP log with Liberty Mutual Insurance Company, was delivered to the insurance company's mailbox on May 27, 1997 (DX 19). Subsequently, through an affidavit, which is accompanied by a copy of the May 21, 1997 Notice of Initial Findings with a Liberty Mutual Insurance Company date stamp, a representative for Liberty Mutual Insurance Company states the company did not receive the Notice of Initial Findings until June 19, 1997 (DX 32).

On July 2, 1997, OWCP issues a Final Decision granting Mrs. Banks survivor benefits and holding Betty B. Coal Company responsible for the payments (DX 20). OWCP also notes Betty B. Coal Company failed to respond within 30 days of the Notice of Initial Findings.

Sometime after July 2, 1997, Betty B. Coal Company receives the July 2, 1997 Final Decision (DX 30). By affidavit, a representative for Betty B. Coal Company states the company did not receive the May 21, 1997 Notice of Initial Findings. The first information the coal company received about the OWCP award of benefits to Mrs. Banks was the July 2, 1997 Final Decision.

On July 14, 1997, counsel for Betty B. Coal Company controverts Mrs. Banks' entitlement to benefits under the Act (DX 21). OWCP receives the letter on July 18, 1997.

On July 23, 1997, OWCP informs counsel for Betty B. Coal Company that his July 14, 1997 controversion was not received within 30 days of the May 21, 1997 Notice of Initial Findings (DX 23). As a result, absence any showing of good cause, OWCP determined that Betty B. Coal

Company had waived its right to contest Mrs. Banks' entitlement to survivor benefits.

With this sequence of events in mind, I first note that an administrative law judge has jurisdiction to conduct a de novo hearing to determine if good cause exists for an employer's failure to timely controvert a claim. *See Frank B. Krizner v. United States Steel Mining Co. Inc.*, 17 B.L.R. 1-31, 1-34 and 1-36 (1992), adopting the Sixth Circuit's holding in *Pyro Mining Co. v. Slaton*, 878 F.2d 187 (6<sup>th</sup> Cir. 1989).

Next, turning to the regulations, the starting point is the definition section of 20 C.F.R. Part 725 (2000).<sup>3</sup> Under the definitions, an "operator" is any entity that operates, controls, or supervises a coal mine, 20 C.F.R. § 725.101 (23) (2000). Based on that definition, Betty B. Coal Company is an operator. An "insurer" is defined as a company authorized to insure an employer's liability under worker compensation laws, 20 C.F.R. § 725.101 (18). Liberty Mutual Insurance Company is such an insurer.

With those definitions in mind, I consider the former provisions, 20 C.F.R. §§ 725.412 and 413 which address issuance of a Notice of Initial Findings and the process for a response.<sup>4</sup> Under 20 C.F.R. § 725.12 (b), after identifying that a responsible coal mine operator may be liable for payments of benefits under the Act, "the deputy commissioner shall notify such operator in writing (emphasis added)." This notice must include a copy of the claimant's claim form, related documents and the deputy commissioner's initial findings. Then, according to 20 C.F.R. § 725.413 (a), "the notified operator shall indicate an intent to accept or contest liability (emphasis added)" within "30 days after receipt of notification under § 725.412 (emphasis added)," unless the period is extended for either good cause or in the interest of justice. According to 20 C.F.R. § 725.413 (b) (3) "[i]f the operator fails to respond within the specified period, such operator shall be deemed to have accepted the initial findings of the deputy commissioner when made and shall not . . . be permitted to raise issues, or present evidence with respect to issue inconsistent with the initial findings (emphasis added)."

Based on the regulations, I find resolution of this issue fairly straightforward. The record contains no documentation that OWCP sent Betty B. Coal Company, the "operator" in this case, a Notice of Initial Findings. In fact, OWCP has not made any such representation, apparently believing service of the Notice of Initial Findings on the Insurer was sufficient. However, the plain language of the regulation requires notification of the "operator."<sup>5</sup> No regulatory reference is made of notice being sent to the insurer.

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<sup>3</sup>In December 2000, new regulations relating to black lung claims were issued. 20 C.F.R. § 725.2 (c) (2000) specifies which subparagraphs are not applicable to claims pending on January 19, 2001. The definition section is not included in those exceptions and thus applies to Mrs. Banks' case.

<sup>4</sup>Under the new regulations, OWCP no longer issues a Notice of Initial Findings.

<sup>5</sup>In holding that the regulations did not require separate notice to an insurer, the Benefits Review Board in *Osborne v. Tazco, Inc.*, 10 B.L.R. 1-102, 1-106 (1987), stated, "Both 20 C.F.R. §§ 752[sic].412 and 725.413 clearly identify the operator as the sole party whom the deputy commissioner is required to notify. . . This is also the Director's interpretation of the regulation."

The absence of any claim by OWCP that the Notice of Initial Findings was sent to Betty B. Coal Company, coupled with the representation by Betty B. Coal Company that it did not receive the Notice of Initial Findings and the lack of any reference to Betty B. Coal Company in OWCP's certified mail log for May 22, 1997 which showed that Mrs. Banks and Liberty Mutual Insurance were sent the Notice of Initial Findings by certified mail, leads to the simple and readily apparent finding that OWCP did not send the coal company the Initial Notice of Findings as required by 20 C.F.R. § 725.413 (a). That omission is unexplained and difficult to understand. OWCP was apparently aware that Betty B. Coal Company was a viable entity since it sent the coal company the notice of Mrs. Banks' claim in April 1997 and the Notice of Final Decision on July 2, 1997.<sup>6</sup>

Consequently, having failed to serve the operator in this case, Betty B. Coal Company, the Notice of Initial Findings, as required by its own regulations, good cause exists to prevent OWCP from invoking the bar associated with the coal company's clearly understandable failure to respond to the May 21, 1997 Notice of Initial Findings within the time frame mandated by 20 C.F.R. §725.413 (b) (3). Consequently, having never received the Notice of Initial Findings, Betty B. Coal Company is excused for good cause for its failure to controvert Mrs. Banks' claim until July 14, 1997, and may address the merits of this case.<sup>7</sup>

## **ISSUE NO. 2 - DEATH DUE TO PNEUMOCONIOSIS**

Having determined that Betty B. Coal Company has shown good cause for untimely controverting this claim, I now must determine of whether Mrs. Banks is entitled to survivor benefits under the Act and the implementing regulations, 20 C.F.R. § 718.205 (a) (2000), which provide benefits to eligible survivors of a miner whose death was due to pneumoconiosis. To obtain benefits, a surviving claimant must prove by a preponderance of the evidence several facts. First, the claimant must establish eligibility as a survivor. A surviving spouse may be considered eligible for benefits under the Act if she was married to, and living with, the coal miner at the time of his death, and has not remarried.<sup>8</sup>

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<sup>6</sup>Betty B. Coal Company responded to the Final Decision within two weeks, objecting to the OWCP findings.

<sup>7</sup>Having resolved this issue based on OWCP's failure to send the Notice of Initial Findings to the operator, I need not address whether a) the Post Office delivered the certified letter to Liberty Mutual Insurance Company on May 27, 1997; or, b) the Liberty Mutual Insurance Company's affidavit stating the company did not receive the notice until June 19, 1997, establishes the actual date of receipt.

<sup>8</sup>20 C.F.R. § 718.4 (2000) indicates that the definitions in 20 C.F.R. § 725.101(2000) are applicable. 20 C.F.R. § 725.101(2000), in turn, refers to the term "survivor" as used in Subpart B of Part 725 (2000). 20 C.F.R. § 725.214 (2000) then sets out the espousal relationship requirements and 20 C.F.R. § 725.215 (2000) describes the dependency rules. According to § 725.214 (a) (2000) the spousal relationship exists if the relationship is a valid marriage under state law. Under § 725.215(a) (2000), a spouse is deemed dependent if she was residing with the miner at the time of his death.

Next, the claimant must prove the coal miner had pneumoconiosis.<sup>9</sup> “Pneumoconiosis” is defined as a chronic dust disease arising out of coal mine employment. The regulatory definitions include both clinical pneumoconiosis (the diseases recognized by the medical community as pneumoconiosis) and legal pneumoconiosis (defined by regulation as any chronic lung disease arising out of coal mine employment) 20 C.F.R. § 718.201 (a) (1) and (2) (2000). The regulation further indicates that a lung disease arising out of coal mine employment includes “any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.” 20 C.F.R. § 718.201 (b) (2000). As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

Third, once a determination has been made that a miner has pneumoconiosis, it must be determined whether the coal miner's pneumoconiosis arose, at least in part, out of coal mine employment.<sup>10</sup> If a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment.<sup>11</sup> Otherwise, the claimant must provide competent evidence to establish the relationship between pneumoconiosis and coal mine employment.<sup>12</sup>

Finally, the surviving spouse has to demonstrate the coal miner's death was due to pneumoconiosis.<sup>13</sup> For a survivor claim filed on or after January 1, 1982, the Department of Labor regulations provide four means to establish that a coal miner's death was due to pneumoconiosis:<sup>14</sup>

1. The miner had complicated pneumoconiosis;<sup>15</sup>
2. Death was caused by pneumoconiosis;
3. Death was caused by complications of pneumoconiosis;
4. Pneumoconiosis was a substantially contributing cause or factor leading to the miner's

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<sup>9</sup>20 C.F.R. § 718.205 (a) (1) (2000) and see *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993).

<sup>10</sup>20 C.F.R. §§ 718.203 (a) and 718.205 (a)(2) (2000).

<sup>11</sup>20 C.F.R. § 718.203 (b) (2000).

<sup>12</sup>20 C.F.R. § 718.203 (c) (2000).

<sup>13</sup>20 C.F.R. § 718.205 (a)(3) (2000).

<sup>14</sup>20 C.F.R. §§ 718.205 (c)(1), (2), and (3), and 718.304 (2000).

<sup>15</sup>According to 20 C.F.R. § 718.304 (2000), if a miner had complicated pneumoconiosis, an irrebuttable presumption exists that his death was due to pneumoconiosis.

death. Notably, pneumoconiosis is deemed to be a substantially contributing cause of a miner's death if it hastens the miner's death.<sup>16</sup>

However, a survivor may not receive benefits if the coal miner's death was caused by traumatic injury, or the principal cause of death was a medical condition not related to pneumoconiosis, unless evidence establishes that pneumoconiosis was a substantially contributing cause of death.

In summary, a survivor claim filed after January 1, 1982 must meet four primary elements for entitlement. The claimant bears the burden of establishing these elements by a preponderance of the evidence. If the claimant fails to prove any one of the requisite elements, the survivor claim for benefits must be denied. *Gee v. W. G. Moore and Sons*, 9 B.L.R. 1-4 (1986) and *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985). The four elements are: (1) the claimant is an eligible survivor of the deceased miner; (2) the coal miner suffered from pneumoconiosis; (3) the coal miner's pneumoconiosis arose out of coal mine employment; and, (4) the coal miner's death was due to coal workers' pneumoconiosis (complicated pneumoconiosis; caused; complications caused; or, substantially contributing cause). As noted below, the stipulations of facts in this case establish the first three requisite elements.

### **Eligible Survivor**

The parties have stipulated that Mrs. Banks is an eligible survivor under the Act. Additionally, the record shows Mr. and Mrs. Banks were married October 7, 1961 (DX 7). Mrs. Banks was living with Mr. Banks and was dependent on him at the time of his death. She has not remarried since his death. Accordingly, Mrs. Banks has established the first entitlement element.

### **Presence of Pneumoconiosis**

The next entitlement element that Mrs. Banks must prove is that Mr. Banks had pneumoconiosis. The parties have stipulated that Mr. John Banks has pneumoconiosis. Consequently, Mrs. Banks has proved the second element of entitlement.

### **Causal Relationship of Pneumoconiosis to Coal Mine Employment**

Having proven that her husband had pneumoconiosis, Mrs. Banks must next demonstrate that

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<sup>16</sup>20 C.F.R. §718.205 (c) (5) (2000). Previously, the U.S. Court of Appeals for the Fourth Circuit had adopted the U.S. Department of Labor's position that pneumoconiosis substantially contributes to death if it hastens death in any way. *Shuff v. Cedar Coal Co.*, 967 F.2d 977, 979 (4th Cir. 1992), *cert. denied*, 113 S.Ct. 969 (1993). See also *Lukosevicz v. Director, OWCP*, 888 F.2d 1001, 1006 (3d Cir. 1989) (any condition, such as pneumoconiosis, that hastens a coal miner's death is a "substantially contributing cause").

her husband's pneumoconiosis was caused, at least in part, by coal mine employment. Under the regulations, if a miner works ten or more years in one or more mines, a presumption exists that his or her pneumoconiosis arose out of coal mine employment. Based on the parties' stipulation that Mr. Banks had at least 14 years of coal mine employment, Mrs. Banks is entitled to the causation presumption. Additionally, the parties also stipulated that Mr. Banks' pneumoconiosis was caused in part by his coal mine employment. Thus, the third element is proven.

### **Death Due to Pneumoconiosis**

With the first three elements of entitlement established, Mrs. Banks need only show that Mr. Banks' death was due to pneumoconiosis in order to receive survivor benefits. As previously discussed, death due to pneumoconiosis may be proven by showing: a) Mr. Banks suffered from complicated pneumoconiosis; b) Mr. Banks' death was caused by pneumoconiosis; c) complications of pneumoconiosis caused his death; or, d) pneumoconiosis was a substantially contributing cause or factor leading to his death (hastened his death).

### **Complicated Pneumoconiosis**

The regulation, at 20 C.F.R. § 718.304 (2000) provides an irrebuttable presumption that the miner's death was due to pneumoconiosis if the miner suffered from a chronic dust disease of the lungs which:

- a) Through diagnostic x-ray interpretations yields an interpretation of one or more large opacities ("greater than 1 centimeter in diameter"), classified as Category A, B, or C, under classification standards; or
- b) Through diagnostic autopsy yields a finding of "massive lesions in the lung; or"
- c) Through "other means" which establish "a condition which could reasonably be expected to yield the results" under the first two methods noted in a) and b) above had the diagnosis been made under those other two provisions.

This type of chronic lung disease is frequently referred to as complicated pneumoconiosis. See *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7, 11, 96 S.Ct. 2882, 49 L.Ed.2d 752 (1976) and *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250, 255 (4th Cir. 2000).

Based on the language of both the Act and regulations, the Benefits Review Board and the courts, have made the determination of complicated pneumoconiosis complicated by requiring two distinct steps in the adjudication.<sup>17</sup>

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<sup>17</sup> Although each of the three methods is separated by the disjunctive "or," the court in *Gray v. SLC Coal* (continued...)

First, an administrative law judge must evaluate the evidence in each category and conduct a separate analysis to determine whether complicated pneumoconiosis is established under one, or more, of the three methods. See *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (*en banc*) and *Scarbro*, *supra*.

Second, prior to invoking the irrebuttable presumption under 20 C.F.R. § 718.304 (2000), the administrative law judge must weigh the determinations under each three methods, using the diagnostic x-ray interpretation method, 20 C.F. R § 718.304 (a) (2000), the most “objective” standard, as the benchmark<sup>18</sup>. The Fourth Circuit in *Scarbro* (affirming its position in *Double B Mining Inc. v. Blankenship*, 177 F.3d 240 (4th Cir. 1999) and adopting Third Circuit’s holding in *Clites v. Jones & Laughlin Steel Corp.*, 663 F.2d 14 (3d Cir. 1981)), declared that the three prongs of § 718.304 (2000) are intended to describe a single, objective condition. *Id.* at 255. Accordingly, as each prong requires a separate analysis, the Court held the administrative law judge must also “perform equivalency determinations to make certain that regardless of which diagnostic techniques is used, the same underlying condition triggers the irrebuttable presumption.” *Scarbro* at 255-256; *Blankenship* at 243; see also *Jones Laughlin Steel Corp.* at 16.

In *Blankenship*, 177 F.3d at 243, the Fourth Circuit further elaborated on this required equivalency determination, stating:

Because prong (A) sets up an entirely objective scientific standard, it provides the mechanism for determining equivalencies under prong (B) or prong (C). In prong (A), Congress mandated that the condition that triggers the irrebuttable presumption is one that creates, on an x-ray, at least one opacity greater than one centimeter in diameter. When that condition is diagnosed by biopsy rather than x-ray, it must therefore be determined whether the biopsy results show a condition that would produce opacities of greater than one centimeter in diameter on an x-ray. That is to say, “massive lesions,” as described in prong (B), are lesions that when x-rayed, show as opacities greater than one centimeter in diameter.

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<sup>17</sup>(...continued)

*Co.*, 176 F.3d 382, 389 (6th Cir. 1999) explained: “Any of the three types of proof is sufficient, in the absence of other evidence, to invoke the irrebuttable presumption, but none is conclusive if outweighed by contrary evidence. This disjunctive therefore serves to give miners flexibility in proving their claims, but does not establish three separate and independent irrebuttable presumptions.”

<sup>18</sup>At least one court seems to disagree on this point. While also requiring consideration of all relevant evidence prior to invoking the presumption, in *Gray v. SLC Coal Co.*, 176 F.3d 382 (6th Cir. 1999), the court stated that x-rays were the “least accurate method” of diagnosing complicated pneumoconiosis. However, Mrs. Banks’ case fall under the jurisdiction of the U.S. Court of Appeals for the Fourth Circuit as set out above in *Scarbro*.

### A. First Step

Based on this judicial guidance, I first will step through each method of establishing complicated pneumoconiosis under 20 C.F.R. § 718.304 (a) to (c) (2000).

#### *Chest X-Rays - 20 C.F.R. § 718.304 (a) (2000)*

Date of x-ray	Exhibit	Physician	Interpretation
06/30/73	DX 48-9	Dr. Sargent, BCR, B <sup>19</sup>	Positive for pneumoconiosis; profusion 1/0; <sup>20</sup> type p/q opacities <sup>21</sup>
06/30/73	DX 48-11	Dr. Proffitt	Negative for pneumoconiosis
09/06/78	DX 49-34	Dr. Jones	Minimal fibrosis; minimal emphysema
05/20/80	DX 48-12	Dr. Maddox	Diffuse pulmonary disease, bilateral, chronic, stable
07/09/80	DX 48-10	Dr. Paranthaman, B	Positive for pneumoconiosis; profusion 1/1; type p opacities
10/22/82	DX 49-34	Dr. Jones	Questionable bronchitis; arteriosclerosis; fibronodose infiltration bilaterally

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<sup>19</sup>B - B Reader; and BCR - Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and an examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

<sup>20</sup>The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1 / 2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2.

<sup>21</sup>There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

<b>Date of x-ray</b>	<b>Exhibit</b>	<b>Physician</b>	<b>Interpretation</b>
(same)	DX 49-34	Dr. Scott, BCR, B	Profusion 0/1; type r/t opacities, negative for pneumoconiosis. <sup>22</sup>
(same)	DX 49-34	Dr. Wheeler, BCR, B	Negative for pneumoconiosis
01/26/83	DX 49-10	Dr. Gaziano, B	Negative for pneumoconiosis
(same)	DX 49-11	Dr. Ramakrishnan, BCR	Positive for pneumoconiosis; profusion 1/2, type p opacities
(same)	DX 49-34	Dr. Wheeler, BCR, B`	Negative for pneumoconiosis
(same)	DX 49-34	Dr. Scott, BCR, B	Negative for pneumoconiosis
(same)	DX 49-34	Dr. Wiot, BCR, B	Negative for pneumoconiosis
(same)	DX 49-34	Dr. Felson, BCR, B	Negative for pneumoconiosis
01/31/83	DX 49-34	Dr. Hashem	Negative for pneumoconiosis
01/25/85	DX 49-12	Dr. Visis	Pulmonary fibrosis of coal workers' pneumoconiosis with mild pulmonary emphysema & calcified arteriosclerosis of the aorta
(same)	DX 49-12 DX 49-34	Dr. Castle, B	Profusion 0/1; type p/s opacities; TB (tuberculosis)
(same)	DX 49-27 DX 49-34	Dr. Stewart, B	Profusion 0/1; type p/t opacities
(same)	DX 49-27 DX 49-34	Dr. Hippensteel, B	Profusion 0/1; type p/s opacities
(same)	DX 49-28 DX 49-34	Dr. Pendergrass	Negative for pneumoconiosis
(same)	DX 49-34	Dr. Wheeler, BCR, B	Negative for pneumoconiosis
(same)	DX 49-34	Dr. Scott, BCR, B	Profusion 0/1; type r/t opacities, negative for pneumoconiosis.
07/01/86	DX 49-23	Dr. Deponte, BCR, B	Large Opacity in right lung apex, maybe cancer, Category A; positive for pneumoconiosis, profusion 2/1; type p/s opacities
(same)	DX 49-34	Dr. Scott, BCR, B	Profusion 0/1; type s/q opacities; negative for pneumoconiosis

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<sup>22</sup>Profusion of 0/1 does not constitute evidence of pneumoconiosis, 20 C.F.R. § 718.102 (b) (2000).

Date of x-ray	Exhibit	Physician	Interpretation
(same)	DX 49-34	Dr. Wheeler, BCR, B	Profusion 0/1; type p/s opacities; cancer, emphysema
(same)	DX 49-34	Dr. Castle, B	Positive for pneumoconiosis; profusion 1/0; type s/q opacities; tuberculosis.
(same)	DX 49-34	Dr. Stewart, B	Positive for pneumoconiosis; profusion 1/0; type q/p opacities
(same)	DX 49-34	Dr. Hippensteel, B	Positive for pneumoconiosis; profusion 1/1; type s/q opacities
10/20/86	DX 49-25	Dr. Westerfield, BCR, B	Positive for pneumoconiosis; profusion 1/2, type q/p opacities
07/02/87	DX 49-30	Dr. Deponte, BCR, B	Large opacity right lung apex unchanged from 1986; doubt cancer; Category A; positive for pneumoconiosis; profusion 1/1; type p/s opacities
(same)	DX 49-34	Dr. Scott, BCR, B	Profusion 0/1; type s/q opacities
(same)	DX 49-34	Dr. Wheeler, BCR, B	Profusion 0/1; type p/s opacities, cancer
(same)	DX 49-34	Dr. Castle, B	Positive for pneumoconiosis, profusion 1/0; type s/q opacities; tuberculosis
(same)	DX 49-34	Dr. Stewart, B	Positive for pneumoconiosis; profusion 1/0; type q/p opacities
(same)	DX 49-34	Dr. Hippensteel, B	Positive for pneumoconiosis; profusion 1/0; type s/q opacities
(same)	DX 49-34	Dr. Nichols, BCR, B	Positive for pneumoconiosis; profusion 1/1; type s/p opacities
08/26/87	DX 49-34	Dr. Sargent, BCR, B	Positive for pneumoconiosis; profusion 1/0; type p/t opacities. Large cavity lesion or nodule in right lung.
09/05/96	DX 9	Dr. Gopalan	New findings of pneumonic infiltrates in left upper and mid lung and right mid lung zone
09/09/96 (a.m.)	DX 9	Dr. Gopalan	Considerable worsening in the appearance of the chest with diffuse infiltrates now seen in the right lung, and worsening of the pneumonic process on the left side
09/09/96 (p.m.)	DX 9	Dr. Gopalan	Diffuse infiltrates seen in both lungs with no improvement in the chest as compared to study done earlier in the day; slight worsening of the pneumonic process

Of the multiple chest x-rays, only three films, July 1, 1986, July 2, 1987, and August 26, 1987, produced interpretations that identified large opacities or nodules. However, Dr. Sargent's finding of a "large" nodule in the August 26, 1987 film, without reference to the appropriate classification standards or the size of the opacity, would not justify a finding of complicated pneumoconiosis. In contrast, Dr. Deponte, a dual qualified radiologist, did see a Category A opacity in Mr. Banks' chest x-ray of July 1, 1986 in accordance with classification standards. However, she suggested the large opacity may be cancer and did not specifically diagnose complicated pneumoconiosis. Even if her Category A finding were considered complicated pneumoconiosis, her assessment is outweighed by the interpretations of two other board certified radiologists, Dr. Scott and Dr. Wheeler, and two B readers, Dr. Castle and Dr. Stewart, that did not identify any large opacities. As a result, based on the preponderance of the evidence, I find the July 1, 1986 does not establish the presence of complicated pneumoconiosis. Just about a year later, Dr. Deponte observed the same large opacity in a July 2, 1987 chest x-ray. Since the size had not changed, she doubted the opacity was cancer but she did not diagnose complicated pneumoconiosis. Once again, even if Dr. Deponte's observation were deemed to be complicated pneumoconiosis, her finding is negated by the preponderance of interpretations of three dual qualified radiologists, Dr. Scott, Dr. Wheeler, and Dr. Nichols, and three B readers, Dr. Castle, Dr. Stewart, and Dr. Hippensteel, that did not identify any large opacities in the same chest x-ray. The July 2, 1987 film also fails to establish complicated pneumoconiosis.

Thus, based on the preponderance of interpretations, the July 1, 1986 and July 2, 1987 chest x-rays, which produced one interpretation each according to classification standards of a large opacity, are actually negative for the presence of a large opacities. Consequently, the radiographic evidence in Mr. Banks' case does not demonstrate that he had a large opacity sufficient within the classification standards to be deemed complicated pneumoconiosis under 20 C.F.R. § 718.304 (a) (2000).

*Autopsy and Biopsy Evidence - 20 C.F.R. § 718.304 (b) (2000)*

(Note: the following summaries, and other remaining portions of this decision, contain detailed information obtained from the autopsy of Mr. Banks, submitted by Mrs. Banks to support her survivor claim. While respecting the dignity and privacy of the deceased, some discussion of the detailed observations is necessary because I find the medical information relevant on determining whether Mr. Banks' death was due to pneumoconiosis.)

Within hours of his death, a chest autopsy of Mr. Banks' was conducted and numerous lung tissue samples were obtained. Prior to reviewing the diverse reports concerning this examination and Mr. Banks' lung tissue, a review of the regulatory provisions on the requisite standard for diagnosing pneumoconiosis based on a biopsy or autopsy helps to understand the significance of some of the reports. The regulations defined "clinical" pneumoconiosis as a condition characterized by permanent deposition of substantial amounts of particulate matter, caused by coal dust exposure, in the lungs and "the fibrotic reaction of the lung tissue to that deposition," 20 C.F.R. § 718.201 (a) (2000) (emphasis added). As a result, an autopsy or biopsy finding of anthracotic pigmentation, standing alone, is not sufficient to establish the presence of pneumoconiosis, 20 C.F.R. § 718.202 (a) (2) (2000). Additionally, a diagnosis of a "chronic lung disease" (complicated pneumoconiosis) may be established if a biopsy or autopsy reveals the presence of massive lesions, 20 C.F.R. § 718.304 (2000).

Dr. Syed Ally  
(DX 9)

On September 10, 1996, Dr. Syed Ally, a board certified pathologist,<sup>23</sup> conducted a post-mortem chest examination of Mr. Banks at Harlan-ARH Hospital. As medical history, Dr. Ally noted Mr. Banks' had previously suffered a stroke and been hospitalized several times for dehydration and urinary tract infections. On September 5, 1996, he was admitted to the hospital for malnutrition and pneumonia. Over the course of his hospitalization, Mr. Banks' pneumonia worsened and he passed away on September 10, 1996. At that time, Mr. Banks was 70 inches tall and weighed 90 pounds.

Upon gross examination, the chest cavity was filled with fluid and the external surfaces of the lungs had extensive patchy, blackish-gray mottled areas with focal fibrous adhesions. When the lungs were sectioned, extensive edema in the form of frothy, flowing fluid, associated with marked congestion, was prominent in the lower lobes. Both lobes showed focal pulmonary emphysema. According to Dr. Ally:

The lungs showed bilateral extensive black macular discoloration with focal micro and occasional macro-nodules measuring from 0.3 to 1 cm in maximum dimension in all lobes bilaterally. Focally, in bilateral upper lobes, in two areas on the right and one on the left showed solid, heavily black pigmented, rubbery to hard areas near the apical portion of the upper lobes with smooth to irregular margins measuring from 2-3 cms in maximum diameter. These areas showed focal empty cyst like cavities measuring from 0.5 to 1 cm.

Gross examination of the heart disclosed mild atherosclerosis.

Under the microscope, all sections of both lungs showed confluent bronchopneumonia. Sections from both lungs also showed extensive pulmonary edema and congestion. The pleural surfaces overlying the pneumonic areas showed inflammatory exudates; and, the surrounding pulmonary parenchyma contained evidence of emphysema. Dr. Ally also observed:

Sections from both lungs showed extensive coal workers' pneumoconiosis with confluent nodular areas showing a focally central hyalinized area surrounded by pigment deposition with fibroblasts and macrophages. . . Sections from the hilar lymph nodes showed anthracotic changes with focal hyalinization and focally hyalinized calcified granuloma formation.

Microscopic review of the coronary arteries confirmed the presence of mild atherosclerotic changes.

Based both on the gross and microscopic evaluations, Dr. Ally diagnosed extensive

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<sup>23</sup>As I advised the parties at the hearing (TR, pages 6 and 7), I take judicial notice of Dr. Ally's board certification and have attached the certification documentation.

bronchopneumonia, pulmonary edema and emphysema, mild atherosclerosis, and “coal workers pneumoconiosis, extensive, confluent micronodules and macronodules with focal complicated pneumoconiosis.”

Dr. Joshua A. Perper  
(DX 9 and DX 10)

On May 7, 1997, Dr. Joshua A. Perper, board certified in anatomical, surgical, and forensic pathology, reviewed the following records and materials: Dr. Ally’s autopsy report, Mr. Banks’ death certificate, the September 1996 hospitalization record, and corresponding chest x-rays.

Dr. Perper examined the pathology slides from the autopsy and observed organizing bronchopneumonia and evidence of chronic emphysema. Dr. Perper reported the lung tissue slides also contained the following:

- Numerous pneumoconiotic anthracotic macules and nodules, both micro-nodules and macro-nodules measuring up to 1.2cm in maximal dimensions. Some of the macro-nodules have a hyaline center and are surrounded by less compact fibro-anthracotic tissue, with spidery like configuration and large numbers of birefringent silica crystals. Around the nodules, scar emphysema is present.
- Severe interstitial fibrosis with marked anthracotic pigmentation. . .
- Peri-vascular fibro-anthraxis with numerous birefringent crystals.
- Focal areas of compact fibro-anthraxis measuring up to 2.5 cm and containing numerous birefringent crystals.

Based on his evaluation, Dr. Perper concluded Mr. Banks had “[c]omplicated coal workers’ pneumoconiosis (PMF),<sup>24</sup> severe, with associated chronic emphysema and severe interstitial anthracofibrosis with silica crystals” which was attributable to his coal mine employment. He further diagnosed acute bronchopneumonia, moderate pulmonary arteriosclerosis, and slight coronary arteriosclerosis. In his opinion, the autopsy report and microscopic findings established that Mr. Banks suffered severe complicated pneumoconiosis with a resulting severe pulmonary insufficiency. According to Dr. Perper, the severe coal workers’ pneumoconiosis was a substantial cause of Mr. Banks’ death, both directly and indirectly. In direct terms, the complicated pneumoconiosis caused severe pulmonary damage with associated emphysema, impaired respiratory functions and hypoxia. In fact, complicated pneumoconiosis is known to cause sudden death. Indirectly, Mr. Banks’ complicated pneumoconiosis predisposed his lungs to infections and his terminal bronchopneumonia.

Dr. Perper acknowledged that Mr. Banks’ prior cerebrovascular accident (stroke) with the

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<sup>24</sup>Pulmonary Massive Fibrosis.

resulting loss of mobility<sup>25</sup> and malnutrition also facilitated the development of pneumonia. However, that condition “does not diminish or negate the important contribution of the severe coal workers’ pneumoconiosis as a substantial contributing cause of death.”

Dr. P. Raphael Caffrey  
(DX 42)

On August 27, 1997, Dr. P. Raphael Caffrey, board certified in anatomical and clinical pathology, conducted a review of Mr. Banks’ medical record since 1992, including the 1996 Wise ARH Hospital records, Dr. Perper’s assessment, Dr. Ally’s autopsy report, and the death certificate. He also microscopically examined the pathology slides from the autopsy of Mr. Banks.

Under the microscope, Dr. Caffrey observed in the slides from the right lung focal areas of acute pneumonia, numerous macules consisting of coal dust surrounded by focal emphysema, centrilobular emphysema, and two 3 millimeter micronodules. The left lung tissue samples contained similar findings of bronchopneumonia, coal dust macules surrounded by focal emphysema, centrilobular emphysema and three nodules, 1 millimeter, 4 millimeters, 5 millimeters and associated anthracotic pigment. The pulmonary lymph node had “multiple nodules with the largest nodule showing calcification.”

Based on these slides, Dr. Caffrey diagnosed acute bronchopneumonia, simple coal workers’ pneumoconiosis that was moderately severe with micronodules, and moderate centrilobular emphysema. In addition, based on his review of cardiac tissue, Dr. Caffrey added mild to moderate coronary artery atherosclerosis.

In analyzing the medical record between 1992 and 1996, Dr. Caffrey observed that Mr. Banks had suffered a CVA (cerebral vascular accident - stroke) with left side paralysis and was bedridden. The CVA was due to the atherosclerosis and a significant factor in Mr. Banks’ death. Mr. Banks died due to a acute bronchopneumonia with abscess formation. Absent the CVA and being bedfast, Mr. Banks most likely would not have developed pneumonia and sepsis; being immobile, he was not able to overcome the severe infection.

Concerning pneumoconiosis, Mr. Banks did have a “significant degree of simple coal workers’ pneumonia with micronodule disease.” All of the nodules in the lung tissue samples were less than 7 mm. As a result, Mr. Banks did not have complicated pneumoconiosis which requires lesions of at least 1cm. Likewise, Dr. Caffrey found no support for Dr. Ally’s diagnosis of complicated pneumoconiosis in Dr. Ally’s microscopic examination. Dr. Caffrey acknowledged that Dr. Ally observed lesions, measuring 2 to 3 cm in the gross examination of the upper lobes. However, Dr. Caffrey stated, “Verification of lesions 2-3 cms is not present in the microscopic slides that I received; therefore, that is why I cannot make a diagnosis of complicated pneumoconiosis.”

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<sup>25</sup>Due to his stroke, Mr. Banks was bedridden the last five years of his life (*see* Dr. Ally’s comments.)

Finally, addressing the relationship between Mr. Banks' coal workers' pneumoconiosis and his death, Dr. Caffrey first observed that his CVA was unrelated to his black lung or coal mine employment. Additionally, Dr. Caffrey couldn't ascertain from the medical records whether Mr. Banks' suffered any pulmonary impairment due to his pneumoconiosis. If Mr. Banks did not have "significant pulmonary problems," then according to Dr. Caffrey, "the simple coal worker's pneumoconiosis with associated micronodular disease would not have been a significant contributing factor leading to death."

Dr. Jeffrey A. Kahn  
(CX 1)

On April 14, 2002, Dr. Jeffrey A. Kahn, board certified in anatomical and clinical pathology,<sup>26</sup> examined the pathology slides and Dr. Ally's autopsy report. In his examination of the lung tissue, Dr. Kahn found multiple coal macules, many with small to moderate size coal nodules. He also saw evidence of emphysema and bronchopneumonia. Dr. Kahn also stated there was no progressive massive fibrosis, the most advanced stage of coal workers' pneumoconiosis. Based on his evaluation, Dr. Kahn diagnosed severe coal workers' pneumoconiosis, pulmonary emphysema, and bronchopneumonia. Dr. Kahn also stated, "My diagnoses in this case are in agreement with those of Syed Ally, MD, the pathologist who did the autopsy."

#### Discussion

Four board certified pathologists revealed Mr. Banks' lung tissue slides and considered Dr. Ally's autopsy report which contained his gross examination remarks. Their opinions are evenly split. Dr. Ally and Dr. Perper diagnosed complicated pneumoconiosis; Dr. Caffrey and Dr. Kahn did not. Due to this conflict, I must first assess the relative probative value of their assessments in terms of documentation and reasoning.

As to the first factor, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter. Finally, in light of the extensive relationship a treating physician may have with a patient, the opinion of such a doctor may be given greater probative weight than the opinion of a non-treating physician. See *Downs v. Director, OWCP*, 152 F.3d 924 (9<sup>th</sup> Cir. 1998). All four pathologists presented well documented medical opinions based both on their personal microscopic evaluations of the lung tissue slides and review of Dr. Ally's report.

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<sup>26</sup>I take judicial notice of Dr. Kahn's board certification and have attached the certification documentation.

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

In terms of reasoning, Dr. Kahn's terse medical opinion suffers a loss of relative probative value for several reasons. First, in particular, Dr. Kahn found "moderate" size coal nodules but did not report their actual dimensions. Absent those measurements, I am unable to determine his criteria for his use of the term "moderate" and or conclusion that no massive fibrosis was present. Next, although he had Dr. Ally's autopsy report, he failed to address Dr. Ally's gross examination findings of three black lesions of 2 to 3 cms on the upper lobes. Third, and significantly, Dr. Kahn's final conclusion about complicated pneumoconiosis is somewhat ambiguous. Although he definitively states he found no progressive massive fibrosis and his diagnosis does not include complicated pneumoconiosis, Dr. Kahn also states his diagnoses agree with Dr. Ally's conclusions. Yet, in his conclusions, Dr. Ally diagnosed "focal complicated pneumoconiosis."

Dr. Caffrey and Dr. Perper presented reasoned medical opinions on the issue of complicated pneumoconiosis. Failing to see any nodule greater than 7 mm, and stating the threshold for complicated pneumoconiosis is 1 cm, Dr. Caffrey's determination that complicated pneumoconiosis was not present is reasonable. At the same time, finding "focal areas of compact fibro-anthraxis measuring up to 2.5 cm," Dr. Perper also reasonably concluded Mr. Banks had complicated pneumoconiosis. Both pathologists apparently reviewed the same lung tissue slides and yet reported starkly contrasting observations.<sup>27</sup> Their directly conflicting observations about the size of the microscopically observable nodules in the lung tissue samples represents an evidentiary stand-off.

That evidentiary equilibrium is tipped towards a finding of complicated pneumoconiosis by Dr. Ally's well reasoned medical opinion. On gross examination, Dr. Ally observed: a) 0.3 to 1 cm black macro-nodule, and b) "focally, in bilateral upper lobes, in two areas on the right and one on the left . . . solid, heavily black pigmented, rubbery to hard areas. . . with smooth to irregular margins measuring from 2-3 cms in maximum diameter." While he didn't specify the dimensions of the microscopic nodules, he did confirm "extensive coal workers' pneumoconiosis with confluent nodular areas." These autopsy findings reasonably support his diagnosis of coal workers' pneumoconiosis with focal complicated pneumoconiosis.

I have considered that based on his own microscopic findings, Dr. Caffrey declined to rely on Dr. Ally's gross examination report of black areas two to three centimeter in diameter to support a finding of complicated pneumoconiosis. Dr. Ally obviously did not share that reservation. As partial

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<sup>27</sup>A possible explanation for the stark differences in their reported observation may be that Dr. Caffrey reports reviewing nine lung tissue samples; whereas, Dr. Perper indicated he examined eleven lung tissue slides. Dr. Kahn reported viewing twelve lung tissue slides.

explanation, Dr. Caffrey stated he wasn't sure whether or not the microscopic slides contained a portion of those lesions. In contrast, having observed and felt the rubbery to hard black areas, and prepared and examined the microscopic samples, Dr. Ally expressed no reservations in concluding Mr. Banks had complicated pneumoconiosis. Dr. Caffrey's approach may be more conservative, but it certainly doesn't set the medical standard or negate Dr. Ally's process and findings. Essentially, Dr. Caffrey discarded a significant gross examination autopsy finding. Dr. Ally did not.

I have also evaluated Dr. Ally's autopsy findings in light of the Fourth Circuit Courts of Appeals' determination in *Double B Mining, Inc. v. Blankenship*, 177 F.3d 240 (4th Cir. 1999), that a physical finding of a two to three centimeter area, coupled with a diagnosis of "massive fibrosis," was insufficient to support a finding of complicated pneumoconiosis. In that case, the court based its holding on the Act's use of the term "massive lesion" rather than "massive fibrosis."<sup>28</sup> However, the situation in Mr. Banks' case is significantly different from the *Blankenship* case. Although Dr. Ally did not use the term "massive lesion" to describe the two to three centimeter hard area in Mr. Banks' lungs, he did use the specific term "complicated pneumoconiosis," which has been previously used to characterized such "massive lesions" in the lungs. See 20 C.F.R. § 410.418 (b), the Social Security Administration regulation on the determination of "complicated pneumoconiosis," which interprets the same Black Lung Benefits Act statutory language.<sup>29</sup>

In light of the diminished probative value of Dr. Kahn's assessment, the findings of Dr. Ally and Dr. Perper that Mr. Banks had complicated pneumoconiosis represent the preponderance of the more probative medical opinion and outweigh Dr. Caffrey's contrary determination. Accordingly, I find the autopsy and biopsy evidence supports a finding of complicated pneumoconiosis.

#### *Other Means - 20 C.F.R. § 718.340 (c) (2000)*

Under the rubric "other means" of establishing complicated pneumoconiosis falls the remaining portions of Mr. Banks' medical record as set out below. See *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (*en banc*).

#### Pulmonary Function Tests

Exhibit	Date/ Doctor	Age/ height	FEV <sub>1</sub> pre post	FV C pre post	MVV pre post	%FEV <sub>1</sub> / FVC pre post	Comments

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<sup>28</sup>The court made this distinction without much discussion on whether those terms may mean the same thing (see the following footnote).

<sup>29</sup>Interestingly, under this regulatory section, an autopsy finding of simple pneumoconiosis, with "progressive massive fibrosis," is considered to be complicated pneumoconiosis. This one provision couples the terms "massive fibrosis," "massive lesions," and "complicated pneumoconiosis" in the determination of complicated pneumoconiosis by autopsy/biopsy evidence under the Act.

DX 49-34	12/03/79 Banchuin	46 71"	3.23	4.2	121	76%	No obstructive or restrictive defect
DX 48-6	07/09/80 Paranthaman	46 70	3.7	4.47	155	82%	Normal spirogram
DX 49-34	01/22/82 Konrad	48 71"	1.16 3.14	4.11 4.1	106 138	28% 76%	Pre: Severe obstructive defect. Borderline restrictive defect after bronchodilator and no obstructive defect
DX 49-7	01/25/83 Kanwal	49 71"	2.22	3.66	140	60%	Obstructive and restrictive pulmonary disease
DX 49-34	08/26/87 Sargent	53 71"	3.33	4.26	61	78%	

#### Arterial Blood Gas Studies

Exhibit	Date/ Doctor	pCO <sub>2</sub> (rest)	pO <sub>2</sub> (rest)	Comments
DX 48-8	07/09/80 Dr. Paranthaman	32 32.1	83.3 84.7	
DX 49-7	01/25/83 Dr. Kanwal	41.1 42.2	76 86.2	Hypoxemia
DX 49-34	08/26/87 Dr. Sargent	37.1	77.8	Essentially normal
DX 15	08/15/96 Dr. Kanwal	40.6	73.1	Dyspnea (labored breathing)
DX 9	09/05/1996 Dr. Escasinas	30.6	64	(Total disability under the regulations <sup>30</sup> )

#### Medical Opinions

Dr. H.H. Howze  
(DX 49-34)

On September 6, 1978, Mr. Banks was admitted to Park Avenue Hospital for acute upper respiratory disease with sinusitis and treated with vasoconstrictors, antibiotics, antihypertensives, and pain medication. Mr. Banks made a very good symptomatic response and was discharged a few days

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<sup>30</sup>To qualify for Federal Black Lung disability benefits at a coal miner's given pCO<sub>2</sub> level, the value of the coal miner's pO<sub>2</sub> must be equal to or less than corresponding pO<sub>2</sub> value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718 (2000). For the pCO<sub>2</sub> of 31, the qualifying pO<sub>2</sub> is 69.

later.

Dr. S.K. Paranthaman  
(DX 48-7)

On July 9, 1980, Dr. S.K. Paranthaman examined Mr. Banks who said that he had been experiencing dyspnea for the last 3 years, especially at night, at least once or twice a week. He felt "choked" and only got relief by sitting up in bed. Mr. Banks also complained of having experienced sharp, left-sided chest pain in the past, lasting for a few seconds. He was on high blood pressure medicine, and smoked one pack of cigarettes per day, for ten years.

Normal spirogram and normal resting and exercise arterial oxygen tension suggested that pulmonary impairment was not significant. However, the chest x-ray film revealed a profusion of 1/1. As a result, Dr. Paranthaman diagnosed hypertension and coal workers' pneumoconiosis.

Dr. Karl Konrad  
(DX 49-34)

On October 22, 1982, Dr. Karl Konrad performed a consultative medical examination to evaluate Mr. Bank's cardiovascular, arthritic and respiratory impairments. In general, Mr. Banks complained of night-time sharp pains in his left chest with feeling of smothering, and a bad back. He reported a 25 pack year history of cigarette smoking. Upon examination, chest configuration was normal. Breath sounds were clear without rales, rhonchi, wheezes or rubs. As a result, Dr. Konrad diagnosed obvious hypertension, which he thought required better treatment.

Dr. Samuel F. Driver  
(EX 13)

On November 4, 1982, Dr. Samuel F. Driver examined Mr. Banks for a disability determination pursuant to the Social Security Act. Even though Mr. Banks said that he was unable to work because of high blood pressure, lower back trouble, arthritis in his spine, and difficulty in breathing, medical evidence revealed no impairment, or combination of impairments, of such severity to impose significant functional restrictions which would interfere with his ability to work. Specifically, special breathing tests did not show any severe reduction in his ability to breathe or in the capacity of his lungs to transfer oxygen to his blood. Consequently, Mr. Banks was not found disabled under the Act.

Dr. G.S. Kanwal  
(DX 49-9 and DX 49, DX 49-34, EX 1, EX 3, DX 8, and EX 17)

On January 25, 1983, Dr. G.S. Kanwal evaluated Mr. Banks. At that time, Mr. Banks revealed that he had been having symptoms of cough, sputum, wheezing and dyspnea for 5 years, notwithstanding his 26 years of coal mine experience and smoking history of 1/2 pack per day for 15

years. Mr. Banks' pulmonary function tests were compatible with obstructive and restrictive pulmonary disease, and his arterial blood gas studies demonstrated hypoxemia. Dr. Kanwal diagnosed chronic bronchitis, pneumoconiosis due to coal dust exposure and severe hypertension.

On January 31, 1983, Dr. Kanwal saw Mr. Banks in an emergency room for severe headaches and high blood pressure. Dr. Kanwal diagnosed severe hypertension.

On July 9, 1992, Dr. Kanwal again treated Mr. Banks in an emergency room for clearing of urinary symptoms and support. After noting that Mr. Bank's hypertension had lead to a cerebrovascular accident ("CVA"), the physician reported Mr. Banks also experienced advanced contractures secondary to urinary tract infection with chronic hematuria, anorexia and weakness. The chest examination disclosed clear chest sounds. Mr. Banks was hospitalized and discharged on July 13, 1992.

On January 22, 1996, Dr. Kanwal treated Mr. Banks for fever. Upon checking Mr. Banks' chest sounds, Dr. Kanwal did not hear any rales or rhonchi. Dr. Kanwal diagnosed old cerebrovascular accident with contractures and hypertension secondary to urinary tract infection. After a few days in the hospital, Mr. Banks was discharged.

Following Mr. Banks' death on September 10, 1996, Dr. Kanwal signed his death certificate on September 13, 1996 without indicating whether an autopsy had been accomplished. He listed Mr. Banks' immediate cause of death as aspiration pneumonia and septicemia. The contributory cause was CVA, with advanced contractures.

On June 10, 2002, in response to a question about Mr. Bank's death, Dr. Kanwal stated "Mr. Banks' did have CWP but I do not feel this contributed to Mr. Banks' death."

Dr. T. Banchuin  
(DX 49-34 and DX 49-8)

On January 25, 1985, Dr. T. Banchuin admitted Mr. Banks to St. Mary's Hospital because of dizziness and staggering from not taking his blood pressure medicine. Mr. Banks also felt his heart skipping. Mr. Banks said he had worked in the mines for 20+ years and had been disabled for the past few years because of back problems. He smoked ½ pack of cigarettes a day. Pulmonary evaluation showed normal respiratory movement. Breath sounds were well distributed, no rales, no rhonchi. Dr. Banchuin diagnosed vertigo, secondary to uncontrolled hypertension. Upon discharge on January 28, 1985, the medical record indicated Mr. Banks' chest x-ray showed pulmonary fibrosis of coal workers' pneumoconiosis with mild pulmonary emphysema and calcified arteriosclerosis of the aorta. Other routine lab tests were non-remarkable. The final diagnosis included hypertension.

Dr. Pierce D. Nelson  
(DX 49-34 and EX 9, EX 10)

On September 5, 1986, Dr. Pierce D. Nelson, board certified in neuropsychiatry and practicing at the SSA Mental Health Clinic, evaluated Mr. Banks for his numerous anxiety related problems of breathing, smothering, back pain, difficulty moving around, and bending lifting and stooping, which Mr. Banks focused on as his main impairment. Testing indicated various problems including chronic maladjustment. However, Dr. Nelson did not address the relationship of these mental issues with Mr. Banks' physical problems.

Dr. Margaret B. Obenschain  
(EX 12)

On October 2, 1986, Dr. Margaret B. Obenschain evaluated Mr. Banks and found his condition non-disabling. Her primary diagnosis was blindness and low vision. Her secondary diagnosis was hypertension. Mr. Banks told Dr. Obenschain that he was unable to work because of high blood pressure, heart attack, dizziness and headaches, arthritis, black lung and poor vision. Mr. Banks also stated he had hardening of the arteries and memory problems. The medical evidence showed that Mr. Banks did have poorly controlled high blood pressure which may have caused headaches and dizziness. But, there was no evidence that this condition had caused significant damage to any of his vital organs. Heart wave tests showed abnormal heart function but did not give clear evidence of a heart attack. There was no evidence of arthritis. Mr. Banks' back, arms and legs were found to be within normal limits on physical examination and did not prevent him from moving about. Mr. Banks did have a mild lung condition, but special breathing tests showed that he could breathe well enough to perform ordinary activity. Medical reports also showed evidence of hardening of the arteries, but there was no record of complaint or treatment for a memory loss. Additionally, Mr. Banks had a problem with poor vision that would prevent him from doing work which required sharp vision.

Dr. Robert O. McGuffin  
(EX 11)

On January 14, 1987, Dr. Robert O. McGuffin conducted a medical record review. His primary diagnosis was visual disturbances; essential hypertension was secondary. While Mr. Banks said that he had breathing problems and black lung, the medical evidence showed that his ability to breathe was within satisfactory limits.

Dr. J. Dale Sargent  
(DX 49-34)

On August 26, 1987, Dr. J. Dale Sargent, board certified in internal medicine and pulmonary disease, examined Mr. Banks. An EKG was consistent with Mr. Banks' known history of arteriosclerotic cardiovascular disease and previous myocardial infarction. A chest x-ray was positive for the presence of an occupational pneumoconiosis. The x-ray also disclosed cavitory lesion in the right upper lobe, which required immediate attention and referral for evaluation. The pulmonary function tests were generally normal with a mildly diminished diffusing capacity. His arterial blood gases showed very mild hypoxemia.

Dr. Sargent concluded Mr. Banks was suffering from simple coal miner's pneumoconiosis. This pneumoconiosis, however, was not associated with a significant ventilatory impairment and his arterial blood gases were also nearly normal. Dr. Sargent stated he did not understand why Mr. Banks had a slightly diminished diffusing capacity, however, this could have been consistent with the presence of an occult pulmonary vascular disease, such as primary pulmonary hypertension or recurrent pulmonary thromboembolic disease.

Dr. Sargent felt that Mr. Banks may have also suffered from bronchogenic carcinoma or tuberculosis as evidenced by his right upper lobe cavity. He did suffer from arteriosclerotic cardiovascular disease and other issues such that Dr. Sargent thought he was totally and permanently disabled on the basis of those illnesses. However, as mentioned, Mr. Banks did not suffer from a ventilatory impairment that could be explained on the basis of his exposure to coal dust.

On September 16, 1987, Dr. J. Dale Sargent again stated Mr. Banks' ventilatory impairment was mild, and from a pulmonary standpoint alone, non-disabling. From a breathing perspective, Dr. Sargent did not expect Mr. Banks to be disabled from doing any job required in the mining of coal.

VA Medical Notes  
(EX 4, EX 5, and EX 6)

On June 2, 1988 and October 10, 1989, Mr. Banks received a diagnosis of "HTN" or hypertension. On August 3, 1990, an additional diagnosis of musculoskeletal neck pain was added.

Dr. Robert J. Dane  
(EX 7 and EX 8)

On October 31, 1988, Dr. Robert J. Dane performed a mental evaluation of Mr. Banks. During the interview, Mr. Banks stated that his heart bothered him, he had hypertension, and arthritis in the spine gave him pain. He was nervous and always tired. He still smoked 1/2 pack per day, but had cut down considerably since his heart attack. Dr. Dane diagnosed Mr. Banks with some mental issues, hypertension, unstable angina, arteriosclerotic heart disease, probable early osteoarthritis, and probable chronic obstructive pulmonary disease.

Dr. Sheshadri  
(EX 2)

On December 30, 1993, Mr. Banks presented to the emergency room at Wise-ARH Hospital with fever and pain in the hips. Mr. Banks' chest sounds were clear. Dr. Sheshadri diagnosed old cerebrovascular accident with residual left hemiplegia and contractures of the extremities secondary

to urinary tract infection. He was discharged on January 3, 1994.

Dr. Edgar Escasinas  
(DX 9)

On September 5, 1996, Mr. Banks presented to the emergency room at Wise ARH Hospital with malnutrition. Since the treating physician, Dr. Kanwal, was unavailable, Dr. Escasinas admitted Mr. Banks and evaluated his situation. Mr. Banks had been bedridden for five years and failed to respond to the dietary guidance from Dr. Kanwal. He also was post cerebrovascular accident with severe flexion contractures. Mr. Banks was awake but lethargic. Upon physical examination, Dr. Escasinas heard diminished breath sounds. A chest x-ray disclosed left-sided pneumoconiosis in the upper and lower lobes. The blood gas study showed  $p\text{CO}_2$  of 30.6; the  $p\text{O}_2$  was 64. Dr. Escasinas diagnosed pneumonia, sepsis, urinary tract infection, and severe malnutrition. He ordered antibiotics and oxygen therapy. (Mr. Banks failed to respond to treatment and passed away the morning of September 10, 1996).

#### Discussion

With an abundance of caution, I have summarized the rest of Mr. Banks' medical history in the record. However, due to the dated nature of the information, most of the documentation does little to support a finding of complicated pneumoconiosis issue.

The pulmonary and arterial blood gas studies indicate that for most of his life up to 1987, despite the presence of coal workers' pneumoconiosis in his lungs, Mr. Banks did not have a disabling respiratory impairment. Chest examinations in 1992, 1993, and January 1996 still indicated clear breathing. However, within a couple weeks of his death, a blood gas study indicated labored breathing and a few days prior to his passing, his blood gas test was low enough to qualify as totally disabling under the regulations. At the same time, absent any physician's statement relating the tests to complicated pneumoconiosis, they do not support such a finding.

Likewise, none of the physicians who evaluated and treated Mr. Banks diagnosed complicated pneumoconiosis. Chronologically, when Mr. Banks first became ill, Dr. S.K. Paranthaman, Dr. G.S. Kanwal, and Dr. J. Dale Sargent diagnosed him with hypertension and coal workers' pneumoconiosis, but neither Drs. Paranthaman nor Sargent found Mr. Banks' condition, from a pulmonary standpoint alone, totally disabling. Other physicians of record, namely, Dr. Samuel F. Driver, Dr. Pierce D. Nelson, Dr. Margaret B. Obenschain, Dr. Robert O. McGuffin, and Dr. Robert J. Dane also examined Mr. Banks for a disability determination and found his ability to breathe well within satisfactory limits. In addition, Drs. Konrad and Banchuin evaluated Mr. Banks for his severe hypertension; and during his last years, Mr. Banks was treated by Drs. Sheshadri and Escasinas for his CVA, pneumonia and urinary tract infections.

These extensive reviews demonstrate no existing diagnosis of a disease process that would cause massive lesions indicative of complicated pneumoconiosis. As a result, no “other means” exists for Mrs. Banks to prove the presence of complicated pneumoconiosis in her husband’s lungs.

### B. Second Step

The second judicially mandated step in the complicated pneumoconiosis analysis involves both a) an evidentiary weighing of any conflicting determinations generated by each of the three methods of diagnosing complicated pneumoconiosis; and b) a closely, related equivalency comparison between any complicated pneumoconiosis finding under the later two methods of determining complicated pneumoconiosis (autopsy/biopsy and “other means”) and the mandated standard of a large opacity on chest x-ray, greater than one centimeter.

#### *Evidentiary Weighing*

In terms of evidentiary weighing, I must assess the probative weight of the diagnosis of complicated pneumoconiosis established by the preponderance of the more probative autopsy/biopsy evidence in relation to the absence of any complicated pneumoconiosis established by any “other means” and the lack of radiographic evidence of complicated pneumoconiosis.

#### “Other Means” vs. Autopsy Findings

The absence of any complicated pneumoconiosis finding through “other means” has reduced probative weight in Mr. Banks’ case because most of that medical evidence is outdated in comparison to the obviously more current autopsy evidence. The only types of medical evidence with nearly the same currency are Dr. Kanwal’s assessment about the relation of pneumoconiosis to Mr. Banks’ death and pulmonary test results and reports within the last nine months of Mr. Banks’ life. Yet, for the reasons noted below, I find none of the more recent “other means” evidence probatively outweighs the autopsy determinations.

The only physician to keep track of Mr. Banks’ condition was his treating physician, Dr. Kanwal. By implication, in his statement (EX 17) that Mr. Banks’ coal workers’ pneumoconiosis did not contribute to his death, Dr. Kanwal did not believe Mr. Banks had complicated pneumoconiosis. As treating physician, Dr. Kanwal was certainly in a position to render a well documented and reasoned medical opinion on whether Mr. Banks had complicated pneumoconiosis. However, due to the terse nature of Dr. Kanwal’s opinion, I am unable to ascertain the underlying documentation or his reasoning. Significantly, Dr. Kanwal does not indicate, either on the death certificate or in his opinion whether he reviewed the autopsy report by Dr. Ally. If he didn’t, then his medical conclusion is not well documented. If he did see the report, then his opinion is not well reasoned because he failed to explain his reasons for disagreeing with Dr. Ally’s finding of complicated pneumoconiosis.

In terms of more recent pulmonary examinations, Dr. Kanwal noted the absence of any rales and rhonchi when he listened to Mr. Banks’ chest in January 1996. However, later in the year, August

1996, when he conducted a blood gas study which did not show a totally disabling oxygenation problem, Dr. Kanwal remarked Mr. Banks had labored breathing. A couple of weeks later, during his last hospitalization, Dr. Escasinas also reported diminished breath sounds and the blood gas study qualified as total disabling. While the later two reports are more likely indicative of Mr. Banks' worsening pneumonia rather than complicated pneumoconiosis, I consider the more recent pulmonary examination evidence, at best, to be inconclusive on whether Mr. Banks had complicated pneumoconiosis. I also note that legally a finding of a totally disabling pulmonary impairment is not a prerequisite for a diagnosis of complicated pneumoconiosis. *See Atkins v. Westmoreland Coal Company*, No. 01-0318, Benefits Review Board, January 18, 2002 (unpublished).<sup>31</sup>

### Radiographic vs. Autopsy Findings

In evaluating the relative probative weight of the radiographic evidence in Mr. Banks' case against the autopsy findings of Dr. Perper and Dr. Ally, the chest x-ray information falls short for essentially the same reason as the "other means" evidence. Other than the three portable chest x-rays taken in September 1996 when Mr. Banks' lungs filled with pneumonia, the radiographic evidence in this record stops in August 1987. Since pneumoconiosis is considered a progressive disease,<sup>32</sup> the absence of a radiographic finding of a large opacity from 1973 through 1987 hardly impeaches autopsy and biopsy findings of large lesions in 1996.

The three chest films from September 1996 were nearly contemporaneous with the autopsy. However, based on the nature of the reports and the actual reported findings, these last three films also are not probative on the issue of complicated pneumoconiosis. In his interpretations, Dr. Gopalan just discussed the worsening nature of the pneumonic infiltrates; he was not evaluating the films for the presence of pneumoconiosis. Notably, and consistent with the radiologist's focus on pneumonia, while the extensive pre-existing radiographic evidence demonstrated that Mr. Banks' lungs contained coal workers' pneumoconiosis opacities, none of the x-ray interpretations in the last days of Mr. Banks' life mentioned the presence of any opacities.

### *Equivalency Determination*

Because I have found that both the radiographic evidence and the "other means" evidence in Mr. Banks' case fails to probatively outweigh the findings of complicated pneumoconiosis by Dr. Ally and Dr. Perper, I must take the final step in this long analytical process and assess whether the diagnoses of Dr. Ally and Dr. Perper would be equivalent to the "objective" standard for complicated pneumoconiosis. In other words, because the chest x-ray standard under 20 C.F.R. § 718.304 (a)

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<sup>31</sup>This decision may be found at [www.dol.gov/brb](http://www.dol.gov/brb) in the unpublished decision sections, January 2002.

<sup>32</sup>An assumption of progressivity underlies much of the Act's regime, *Scarbro*, 220 F.3d at 258. "Complicated pneumoconiosis is progressive, and often takes years to manifest," *Gray*, 176 F.3d at 386.

contains an “objective” standard, that is, the requirement of an opacity greater than one centimeter, the Fourth Circuit Court of Appeals stated that it provides the benchmark for defining “massive lesion” in an autopsy under 20 C.F.R. § 718.304 (b), *Scarbro*, 220 F.3d at 256.

In review, during gross examination of Mr. Banks’ lungs, after finding and manipulating three solid black areas measuring 2 to 3 centimeters, Dr. Ally diagnosed complicated pneumoconiosis. In a similar manner, based both on Dr. Ally’s autopsy report and his own microscopic finding of a 2.5 centimeter macronodule, Dr. Perper concluded Mr. Banks had complicated pneumoconiosis. Neither Dr. Ally nor Dr. Perper were called upon to opine whether their physical, and highly definitive, findings would equate to an opacity image greater than one centimeter on a hypothetical chest x-ray. Consequently, in the absence of that specific medical finding, I apply common sense to conclude hard, macro nodules actually present in lung tissue measuring 2 to 3 centimeters would appear at least greater than one centimeter in diameter in a chest x-ray. Specifically, I find the autopsy/biopsy findings of Dr. Ally and Dr. Perper are the equivalent of the requisite radiographic benchmark under 20 C.F.R. § 718.304 (a) (2000).

My common sense determination does not stand alone. Although the Fourth Circuit Court of Appeals has declined to apply a bright line rule, the court did observe “the Pneumoconiosis Committee of the College of American Pathologists long ago set two centimeters as the minimum diameter for a lesion to constitute complicated pneumoconiosis.” *Double B. Mining, Inc. v. Blankenship*, 177 F.3d 240, 244 (4th Cir. 1999). Recently, in *Braenovich v. Cannerton Industries, Inc.*, No. 02-0365 BLA (Feb. 12, 2003), the Board upheld an administrative law judge’s “equivalency determination that a 1.5 centimeter lesion on autopsy would constitute a 1.0 centimeter or greater opacity on a chest x-ray.”

### C. Conclusion

Since the preponderance of the more probative autopsy/biopsy evidence outweighs the absence of complicated pneumoconiosis findings under the other two prongs of 20 C.F.R. § 718.304 (2000), and the autopsy/biopsy findings are equivalent to, if not more than, the “objective” bench mark under 20 C.F.R. § 718.304 (a) (2000), I find Mr. Banks had complicated pneumoconiosis. Accordingly, Mrs. Banks is entitled to invoke the irrebuttable presumption of 20 C.F.R. § 718.304 (2000) that Mr. Banks’ death was due to pneumoconiosis. Since this presumption is irrebuttable and Mrs. Banks has proven the first three elements of entitlement (eligible survivor, presence of pneumoconiosis, and pneumoconiosis arising out of coal mine employment), Mrs. Banks’ claim for survivor benefits must be approved.

### **Death Caused By Pneumoconiosis<sup>33</sup>**

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<sup>33</sup> Although the presence of complicated pneumoconiosis invokes an irrebuttable presumption and establishes Mrs. Banks’ entitlement to survivor benefits, I will also address whether any other aspect of this case supports Mrs. Banks’ survivor claim.

The record contains insufficient evidence to conclude that pneumoconiosis killed Mr. Banks. Dr. Perper was the only physician to suggest the pneumoconiosis may have caused Mr. Banks to die. In explaining his opinion that Mr. Banks' severe coal workers' pneumoconiosis was a direct factor in his death, Dr. Perper stated that complicated pneumoconiosis is known to cause "sudden death." To the extent that Dr. Perper intended that statement to mean pneumoconiosis killed Mr. Banks, it is not well stated or reasoned. Specifically, Dr. Perper did not say Mr. Banks experienced such a sudden death. Additionally, contrary to experiencing a sudden death, Mr. Banks struggled with pneumonia and infection for a few weeks in August and September 1996 before his defenses succumbed. Consequently, I find insufficient evidence to conclude pneumoconiosis caused Mr. Banks' death.

### **Death Caused By Complications Of Pneumoconiosis**

Concerning the role of complications of pneumoconiosis played, three physicians expressed contrary opinions. Based on his terse statement and death certificate findings that Mr. Banks died due to aspiration pneumonia associated with the CVA, Dr. Kanwal did not believe pneumoconiosis contributed to Mr. Banks' death. For a different reason, Dr. Caffrey reached a similar conclusion. In the absence in the medical record of any "significant pulmonary problems," Dr. Caffrey stated Mr. Banks' simple coal workers' pneumoconiosis would not have been a significant contributing factor in his death. Of course, Dr. Perper disagreed. In his comments about the direct link between Mr. Banks' severe pneumoconiosis and his death, Dr. Perper also explained that complicated pneumoconiosis can cause "severe pulmonary damage" with associated emphysema, impaired respiratory function and hypoxia. The circumstances of Mr. Banks' death indicates that in the last days of his life, Mr. Banks did have respiratory difficulties and hypoxia.

As previously discussed, due to the conflict in medical opinion, I must assess relative probative value to these three opinions. Also as previously explained, for lack of sufficient stated documentation and reasoning, Dr. Kanwal's conclusions are the least probative. Although he was obviously very familiar with Mr. Banks' medical situation as the treating physician, the record contains only his brief medical notes from his visits with Mr. Banks, cause of death notation on the death certificate and a one line response about the relationship between pneumoconiosis and Mr. Banks' demise. Since he signed the death certificate, I might assume that Dr. Kanwal was aware of the circumstances of Mr. Banks' last hospitalization and the autopsy report. Yet, his one line causation statement does not reference the documentation forming the foundation for his opinion. Obviously closely related, Dr. Kanwal's assessment also has little probative value because it is likewise unaccompanied by any explanation.

In contrast, both Dr. Caffrey and Dr. Perper presented well documented medical opinions that once again represent an evidentiary impasse. Since neither Dr. Ally nor Dr. Kahn, the other pathologists familiar with Mr. Banks' lung tissue, rendered an opinion on the relationship between Mr. Banks' death and his black lung disease, Dr. Caffrey and Dr. Perper remain in a sufficient deadlock to preclude my finding that Mr. Banks died due to complications of pneumoconiosis.

### **Pneumoconiosis Was a Substantially Contributing Cause Of, Or Hastened, Death**

Even though neither pneumoconiosis nor its complications caused Mr. Banks' death, Mrs.

Banks may still be entitled to survivor benefits if pneumoconiosis was a substantially contributing cause of her husband's death. In addressing this basis for entitlement, it is important to remember that the courts have interpreted "substantially contributing cause" to mean "hastened." Adopting that standard, the new regulation, 20 C.F.R. § 718.205 (c) (2000), states pneumoconiosis is "'substantially contributing cause' of a miner's death if it hastens death." That is, if pneumoconiosis cut short Mr. Banks' life in any manner, Mrs. Banks may prevail with her survivor claim.

Again, based on their opinions, Dr. Kanwal and Dr. Caffrey do not believe coal workers' pneumoconiosis was a substantially contributing factor; Dr. Perper believes that it was. For the previously discussed documentation and reasoning shortfalls, Dr. Kanwal's opinion is not probatively helpful.

So, I return to the standoff between Dr. Caffrey and Dr. Perper. However, on this issue, the tie is broken and Dr. Perper prevails for the following reasons. First, Dr. Caffrey makes clear that he requires evidence of a significant pulmonary impairment in order to conclude that simple coal workers' pneumoconiosis was a significant contributing factor leading to death. Because Mr. Banks did not have "significant pulmonary problems," Dr. Caffrey opined black lung disease was not a "significant contributing factor leading to death." While there may be a medical basis for his opinion, the requirement of a significant pulmonary impairment is inconsistent with the legal meaning of "substantially contributing factor" as the hastening of death in any manner.

Second, the applicability of the hastening standard, and Dr. Caffrey's reasoning deficiency on the issue, become readily apparent in Mr. Banks' case because he clearly died a pulmonary death due to pneumonia. Dr. Caffrey indicates the five year consequences of Mr. Banks' CVA, notably his being bedfast, eventually prevented him from overcoming the severe pulmonary infection. Yet, because he required, and didn't find, evidence of a significant pulmonary impairment, Dr. Caffrey discounted pneumoconiosis as a significant contributing factor when even his own findings establish that Mr. Banks had extensive coal workers' pneumoconiosis with associated micronodule disease throughout his lungs as he attempted to combat a pulmonary infection and pneumonia.

Third, in contrast, Dr. Perper presented a well reasoned opinion which is more consistent with the hastening death standard and consequently the most probative medical opinion on whether coal workers' pneumoconiosis was a substantial contributing factor in the passing of Mr. Banks. Unlike Dr. Caffrey, Dr. Perper recognized both the adverse effects of Mr. Banks' CVA and his coal workers' pneumoconiosis. Acknowledging that Mr. Banks' CVA-induced immobility and malnutrition "facilitated" the development of the deadly pneumonia, Dr. Perper also stressed the obvious pulmonary weakness of Mr. Banks' lungs due to his pre-existing severe, and widespread, coal workers' pneumoconiosis. While being predisposed to lung problems due his CVA, Mr. Banks suffered with severe coal workers' pneumoconiosis which also predisposed his lungs to infections and his terminal bronchopneumonia. The predisposition to pneumonia due to the CVA did "not diminish, or negate" the effect of Mr. Banks' "severe coal workers' pneumoconiosis as a substantial contributing cause of death."

In summary, both Dr. Kanwal (due to insufficient reasoning and lack of stated documentation) and Dr. Caffrey (due to his significant pulmonary impairment prerequisite) presented opinions on the substantial contributing cause issue which have diminished probative value. The remaining medical opinion on the issue by Dr. Perper is well documented and reasoned, and represents the preponderance of the more probative medical opinion. Based on Dr. Perper's medical opinion, Mrs. Banks has proven that coal workers' pneumoconiosis substantially contributed to, and hastened, the death of her husband, Mr. John Banks. Accordingly, under the provisions of 20 C.F.R. §§ 718.205 (a) and (c) (2) (2000), Mrs. Banks is entitled to survivor benefits under the Act.

### **CONCLUSION AND DATE OF ENTITLEMENT**

The more probative autopsy/biopsy evidence establishes that Mr. Banks had complicated pneumoconiosis. As a result, the irrebuttable presumption under 20 C.F.R. §718. 304 (2000) is invoked and Mr. Banks' death was due to pneumoconiosis. The more probative medical opinion also establishes that coal workers' pneumoconiosis substantially contributed to, and hastened, Mr. Banks' death. Accordingly, for each reason separately, under 20 C.F.R. §§ 718.205 (a), (c) (2), and (c) (3) (2000), Mrs. Banks' claim for survivor benefits under the Act must be approved.

In the case of a coal miner who died due to pneumoconiosis, benefits to the survivor are payable beginning the month the coal miner died. 20 C.F.R. §725.503 (c) (2000). Since Mr. Banks expired on September 10, 1996, Mrs. Banks' benefits are payable beginning September 1, 1996.

### **ORDER**

The claim of CARRIE B. BANKS for survivor benefits under the Act is **GRANTED**. The Employer, BETTY B. COAL COMPANY, is ordered to pay the claimant all survivor benefits to which she is entitled under the Act and Regulations. Benefits shall commence September 1, 1996.

**SO ORDERED:**

**A**

RICHARD T. STANSELL-GAMM  
Administrative Law Judge

Date Signed: April 30, 2003  
Washington, DC

**NOTICE OF APPEAL RIGHTS:** Pursuant to 20 C.F.R. § 725.481 (2000), any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Workers' Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box

37601, Washington, DC 20013-7601. See 20 C.F.R. § 725.478 and § 725.479 (2000). A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, DC 20210.

Attachment No. 1

American Board of Medical Specialties«

Certification:

Syed A.I. Ally, MD

Certified by: The American Board of Pathology:

Anatomic and Clinical Pathology

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Attachment No. 2

American Board of Medical Specialties«

Certification:

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